		FOR BHF USE					

LL1

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

I. IDPH License ID Number: 0047357

Facility Name: Nature Trail Health Care Ctr

Address: 1001 South 34th St (Number) Mount Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: 618 242 5700 **Fax #** 618 242 1572

HFS ID Number:

Date of Initial License for Current Owners: 10/06/2005

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Martha McDaniel **Telephone Number:** 832 467 6317
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2020 to 12/31/2020 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Chris Stenger
(Title) SVP Operations Finance

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	19	Skilled (SNF)	19	6,954	1
2		Skilled Pediatric (SNF/PED)			2
3	55	Intermediate (ICF)	55	20,130	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,084	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	190	111	4,502	4,803	8
9	SNF/PED					9
10	ICF	9,642	780	3,959	14,381	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	9,832	891	8,461	19,184	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.83%

D. How many bed reserve days during this year were paid by the Department?
42 (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/2005

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/2005 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 74 and days of care provided 3,994

Medicare Intermediary Novitas

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2020 Fiscal Year: 12/31/2020

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		2,913	314,899	317,812		317,812	(72,132)	245,680			1
2	Food Purchase		1,278		1,278		1,278	71,736	73,014			2
3	Housekeeping		6,518	68,038	74,556		74,556		74,556			3
4	Laundry		6,007	42,427	48,434		48,434		48,434			4
5	Heat and Other Utilities			62,548	62,548		62,548	(4,843)	57,705			5
6	Maintenance	42,999	56,519	6,620	106,138		106,138	17,891	124,029			6
7	Other (specify):*			12,693	12,693		12,693	(63,931)	(51,238)			7
8	**TOTAL General Services**	42,999	73,235	507,225	623,459		623,459	(51,279)	572,180			8
	B. Health Care and Programs											
9	Medical Director			33,590	33,590		33,590		33,590			9
10	Nursing and Medical Records	1,472,660	142,010	22,322	1,636,992		1,636,992	171,303	1,808,295			10
10a	Therapy	547,014	23,244	919	571,177		571,177		571,177			10a
11	Activities	49,600	3,179	4,189	56,968		56,968		56,968			11
12	Social Services	37,372		2,399	39,771		39,771		39,771			12
13	CNA Training											13
14	Program Transportation	32,644	4,740	9,454	46,838		46,838		46,838			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,139,290	173,173	72,873	2,385,336		2,385,336	171,303	2,556,639			16
	C. General Administration											
17	Administrative	118,150			118,150		118,150	2,884	121,034			17
18	Directors Fees											18
19	Professional Services			2,912	2,912		2,912	14,269	17,181			19
20	Dues, Fees, Subscriptions & Promotions			32,818	32,818		32,818	(669)	32,149			20
21	Clerical & General Office Expenses	179,051	13,533	435,575	628,159		628,159	(285,790)	342,369			21
22	Employee Benefits & Payroll Taxes			378,786	378,786		378,786	24,555	403,341			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,208	10,208		10,208	(5,156)	5,052			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			339,524	339,524		339,524	(277,795)	61,729			26
27	Other (specify):*											27
28	**TOTAL General Administration**	297,201	13,533	1,199,823	1,510,557		1,510,557	(527,702)	982,855			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,479,490	259,941	1,779,921	4,519,352		4,519,352	(407,678)	4,111,674			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Nature Trail Health Care Ctr #0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			319,843	319,843		319,843	(39,114)	280,729			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			435,683	435,683		435,683	27,530	463,213			32
33	Real Estate Taxes			32,230	32,230		32,230	(641)	31,589			33
34	Rent-Facility & Grounds			6,000	6,000		6,000		6,000			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*							20,701	20,701			36
37	**TOTAL Ownership**			793,756	793,756		793,756	8,476	802,232			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		144,361	78,537	222,898		222,898		222,898			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			131,347	131,347		131,347		131,347			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		144,361	209,884	354,245		354,245		354,245			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,479,490	404,302	2,783,561	5,667,353		5,667,353	(399,202)	5,268,151			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(379)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,879)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,931)	7		24
25	Fund Raising, Advertising and Promotional	(1,059)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (70,265)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	303,148		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 303,148		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 232,883		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Nature Trail Health Care Ctr

ID# 0047357

Report Period Beginning: 01/01/2020

Ending: 12/31/2020

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Back Office Services	$ (288,371)	21	1
2	Prof Liability Insurance Adjustment	(287,109)	26	2
3	Depreciation Adj Capital Lease Days	(39,114)	30	3
4	Reclass Raw Food Expense	(72,132)	1	4
5	Reclass Raw Food Expense	72,132	2	5
6	Real Estate Accural Adj	(641)	33	6
7	Adjust Travel Expense	(16,850)	24	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(632,085)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(72,132)	0	0	0	0	0	0	0	0	0	0	(72,132)	1
2	Food Purchase	71,736	0	0	0	0	0	0	0	0	0	0	71,736	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,879)	36	0	0	0	0	0	0	0	0	0	(4,843)	5
6	Maintenance	0	17,891	0	0	0	0	0	0	0	0	0	17,891	6
7	Other (specify):*	(63,931)	0	0	0	0	0	0	0	0	0	0	(63,931)	7
8	**TOTAL General Services**	(69,206)	17,927	0	0	0	0	0	0	0	0	0	(51,279)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	171,303	0	0	0	0	0	0	0	0	0	171,303	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	171,303	0	0	0	0	0	0	0	0	0	171,303	16
	C. General Administration													
17	Administrative	0	2,884	0	0	0	0	0	0	0	0	0	2,884	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	14,269	0	0	0	0	0	0	0	0	0	14,269	19
20	Fees, Subscriptions & Promotions	(1,059)	390	0	0	0	0	0	0	0	0	0	(669)	20
21	Clerical & General Office Expenses	(288,371)	2,581	0	0	0	0	0	0	0	0	0	(285,790)	21
22	Employee Benefits & Payroll Taxes	0	24,555	0	0	0	0	0	0	0	0	0	24,555	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(16,850)	11,694	0	0	0	0	0	0	0	0	0	(5,156)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(287,109)	9,314	0	0	0	0	0	0	0	0	0	(277,795)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(593,389)	65,687	0	0	0	0	0	0	0	0	0	(527,702)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(662,595)	254,917	0	0	0	0	0	0	0	0	0	(407,678)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 **Report Period Beginning:** 01/01/2020 **Ending:** 12/31/2020

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(39,114)	0	0	0	0	0	0	0	0	0	0	(39,114)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	27,530	0	0	0	0	0	0	0	0	0	27,530	32
33	Real Estate Taxes	(641)	0	0	0	0	0	0	0	0	0	0	(641)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	20,701	0	0	0	0	0	0	0	0	0	20,701	36
37	**TOTAL Ownership**	(39,755)	48,231	0	0	0	0	0	0	0	0	0	8,476	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(702,350)	303,148	0	0	0	0	0	0	0	0	0	(399,202)	45

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Illinois Holdco LLC	100	Montebello Health Care Center	Hamilton	SSC Equity Holdings LLC		Holding Company
		Nature Trail Health Care Center	Mount Vernon	SSC Administrative Services LLC		Back Office Service
		Odin Health Care Center	Odin	SSC Consulting Services LLC		Consulting Services
		Westchester Healthcare Center0	Westchester			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	SSC Equity Holdings LLC	100.00%	$ 36	$ 36	1
2	V	6	Repair and Maintenance		SSC Equity Holdings LLC	100.00%	17,891	17,891	2
3	V	19	Professional Services		SSC Equity Holdings LLC	100.00%	14,269	14,269	3
4	V	20	Fee, Subscriptions and Promos		SSC Equity Holdings LLC	100.00%	390	390	4
5	V	10	Nursing & Medical Records		SSC Equity Holdings LLC	100.00%	171,303	171,303	5
6	V	21	Clerical & Gen Office Exp		SSC Equity Holdings LLC	100.00%	2,581	2,581	6
7	V	24	Travel & Seminar		SSC Equity Holdings LLC	100.00%	11,694	11,694	7
8	V	26	Insurance		SSC Equity Holdings LLC	100.00%	9,314	9,314	8
9	V	36	Depreciation		SSC Equity Holdings LLC	100.00%	20,701	20,701	9
10	V	17	Communications		SSC Equity Holdings LLC	100.00%	2,884	2,884	10
11	V	35	Rental and Lease		SSC Equity Holdings LLC	100.00%			11
12	V	32	Interest Income/Expense		SSC Equity Holdings LLC	100.00%	27,530	27,530	12
13	V	22	Payroll Taxes		SSC Equity Holdings LLC	100.00%	24,555	24,555	13
14	Total			$			$ 303,148	$ * 303,148	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holdings Company LLC		Excell Health Care Center	Oakland				1
2			Flagship Heath care Center	Newport Beach				2
3			Tarzana Health & Rehab Center	Tarzana				3
4			Diamond Ridge Health Care Center	Pittsburgh				4
5			Courtyard Care Center	San Jose				5
6			Mission Carmichael Health Care Center	Carmichael				6
7			AlpineLiving Center	Thornton				7
8			Boulder Manor	Boulder				8
9			Pearl Street Health Care Center	Englewood				9
10			Applewood Living Center	Longmont				10
11			Fort Collins Health Care Center	Fort Collins				11
12			Spring Creek Healthcare Center	Fort Collins				12
13			Berthoud Living Center	Berthoud				13
14			Sierra Vista Health Care Center	Loveland				14
15			Windsor Health Care Center	Windsor				15
16			San Juan Living Center	Montrose				16
17			Four Corners Health Care Center	Durango				17
18			Palisade Living Center	Palisade				18
19			Colonial Columns Nursing Center	Colorado Springs				19
20			Cedarwood Health Care Center	Colorado Springs				20
21			Minnequa Medicenter	Pueblo				21
22			Terrace Gaedens Healthcare Center	Colorado Springs				22
23			Aspen Living Cente	Colorado Springs				23
24			Centennial Heathcare Center	Greeley				24
25			Kenton Manor	Greeley				25
26			Stering Living Center	Sterling				26
27			Sunset Manor	Brush				27
28			Yuma Life Care Center	Yuma				28
29			Jewell Care Center of Denver	Denver				29
30			Monaco Parkway	Denver				30

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC		Garden Square at Spring Creek	Fort Collins				1
2			Pendleton Health & Rehab	Mystic				2
3			Bride Brook Health & Rehab	Niantic				3
4			Brian Center Nursing Care Austell	Austll				4
5			Brian Center Health & Rehab Canton	Canton				5
6			Northeast Atlanta Healty & Rehab	Atlanta				6
7			Brighton Place West	Topeka				7
8			Indian Creek Healht Care Center	Overland Park				8
9			SE Massachusetts Health & Rehab	New Bedford				9
10			Methuen Health & Rehab Center	Methuen				10
11			Patuxent River Health & Rehab Center	Laurel				11
12			Arcola Heatlh & Rehab Center	Silver Spring				12
13			Glen Burnie Health & Rehab Center	Glen Burnie				13
14			Overlea Health & Rehab Center	Baltimore				14
15			Bethesda Health & Rehab Center	Bethesda				15
16			Summit Park Health & Rehab Center	Catonsville				16
17			North Arundel Health & Rehab Center	Glen Burnie				17
18			Bel Air Health & Rehab Center	Bel Air				18
19			Forest Hill Health & Rehab Center	Forest Hill				19
20			Heritage Harbour Health & Rehab Center	Annapolis				20
21			Cambridge East	Madison Heights				21
22			Cambridge North	Clawson				22
23			Cambridge South	Beverly Hills				23
24			Clarkston	Clarkston				24
25			Clinton-Aire Healthcare Center	Clinton Township				25
26			Crestmont NursingCare Center	Fenton				26
27			Heritage Manor	Flint				27
28			Hope Health Care Center	Westland				28
29			Warren Woods Health Care Center	Warren				29
30			Superior Woods Health Care Center	Ypsilanti				30

IF THIS PAGE IS NOT NEEDED, YOU MAY HIDE IT SO IT WILL NOT PRINT

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Countrybrook Living Center	Brook Haven				1
2			Brian Center Health & Rehab Eden	Eden				2
3			Brian Center Nursing Care Lexington	Lexington				3
4			Brian Center Health & Rehab Hickory East	Hickory				4
5			Brian Center Health & Rehab Wilson	Wilson				5
6			Randolph Health & Rehab Center	Asheboro				6
7			Brian Center Health & Rehab Winston Salem	Winston Salem				7
8			Brian Center Health & RehabCharlotte	Charlotte				8
9			Brian Center Health & Rehab Windsor	Windsor				9
10			Maple Leaf Health Care	Statesville				10
11			Brian Center Health & Rehab Weaverville	Weaverville				11
12			Brian Center Health & Rehab Lincolnton	Lincolnton				12
13			Brian Center Health & Rehab Wallace	Wallace				13
14			Brian Center Health & Rehab Monroe	Monroe				14
15			Brian Center Health & RehabDurham	Durham				15
16			Brian Center Health & Rehab Goldsboro	Goldsboro				16
17			Brian Center Health & Rehab Cabarrus	Concord				17
18			Brian Center Nursing Care Shamrock	Charlotte				18
19			Brian Center Nursing Care Hickory	Hickory				19
20			Brian Center Health & Rehab Center Waynesvi	Waynesville				20
21			Brian Center Health & Rehab Clayton	Clayton				21
22			Brian Center Health & Rehab Brevard	Bervard				22
23			Brian Center Health & Rehab Yanceyville	Yanceyville				23
24			Brian Center Health & Rehab Hertfort	Hertford				24
25			Brian Center Health & Rehab Spruce Pine	Spruce Pine				25
26			Brian Center Health & Rehab Hendersonville	Hendersonville				26
27			Brian Center Health & Rehab Salisbury	Salisbury				27
28			Mariner Health Care of Wilmington	Wilmington				28
29			Silver Stream Health & Rehab	Wilmington				29
30			Kenansville Health & Rehab	Kenansville				30

IF THIS PAGE IS NOT NEEDED, YOU MAY HIDE IT SO IT WILL NOT PRINT

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Charlotte Apts	Charlotte				1
2			Forest City Health & Rehab	Forest City				2
3			North Hills Health & Rehab	Wexford				3
4			West Hills Health & Rehab	Coraopolis				4
5			Broomall Health & Rehab	Broomall				5
6			Seneca Health & Rehab	Senaca				6
7			Sumter East Health & Rehab	Sumter				7
8			Golden Age Inman	Inman				8
9			Inman Healthcare	Inman				9
10			Lebanon Health & REhab	Lebanon				10
11			Greenhills Health & Rehab	Nashville				11
12			Norris Health & Rehab	Andersonville				12
13			Newport Health & Rehab	Newport				13
14			Cheyenne Healthcare	Cheyenne				14
15			Poplar Living Center	Casper				15
16			Sheridan Manor	Sheridan				16
17			Huntington Health Care	Huntington				17
18			Bastrop Nursing Center	Bastrop				18
19			Care Inn of La Grange	La Grange				19
20			Kountze Nursing Center	Kountze				20
21			Retama Manor Nursing Center San Antonio No	San Antonio				21
22			Retama Manor Nursing Center San Antonio We	San Antonio				22
23			Retama Manor Nursing Center Alice	Alice				23
24			Retama Manor Nursing Center Edinburg	Edinburg				24
25			Retama Manor Nursing Center Harlingen	Harlingen				25
26			Retama Manor Nursing Center Jourdanton	Jourdanton				26
27			Retama Manor Nursing Center Laredo South	Laredo				27
28			Retama Manor Nursing Center Laredo West	Laredo				28
29			Retama Manor Nursing Center McAllen	McAllen				29
30			Retama Manor Nursing Center Pleasanton Nort	Pleasanton				30

IF THIS PAGE IS NOT NEEDED, YOU MAY HIDE IT SO IT WILL NOT PRINT

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Retama Manor Nursing Center Pleasanton Sout	Pleasanton				1
2			Retama Manor Nursing Center Rio Grande City	Rio Grande City				2
3			Retama Manor Nursing Center Robstown	Robstown				3
4			Retama Manor Nursing Center Weslaco	Weslaco				4
5			Weatherford health Care Center	Weatherford				5
6			Peach Tree Place	Weatherford				6
7			Retama Manor Nursing Center Raymondville	Raymondville				7
8			Memorial City Health and Rehab	Houston				8
9			Jacinto City Healthcare Center	Houston				9
10			Spring Branch Healthcare Center	Houston				10
11			Retama Manor Nursing Center Corpus Christi I	Corpus Christi				11
12			Downtown Health & Rehab	Fort Worth				12
13			Lakeshore Village Healthcare Center	Waco				13
14			Deer Creek of Wimberley	Wimberley				14
15			La Paloma Nursing Center	San Diego				15
16			Pine Arbor	Silsbee				16
17			Las Palmas Healthcare Center	McAllen				17
18			Hilltop Village	Kerville				18
19			Silver Creek Manor	San Antonio				19
20			Alpine Terrace	Kerrville				20
21			Edgewater Care Center	Kerrville				21
22			Arlington Heights Health & Rehab	Fort Worth				22
23			The Meadows Health & Rehab	Dallas				23
24			Northgate Health & Rehab	San Antonio				24
25			Interlochen Health & Rehab	Arlington				25
26			First Colony Health & Rehab	Missouri City				26
27			Cypresswood Health & Rehab	Houston				27
28			Northwest Health & Rehab	Houston				28
29			The Westbury Place	Houston				29
30			Westchase Health & Rehab	Houston				30

IF THIS PAGE IS NOT NEEDED, YOU MAY HIDE IT SO IT WILL NOT PRINT

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	SSC Equity Holding Company LLC	100	Woodwind Lakes Health & Rehab	Houston				1
2			Pasadena Care Center	Pasadena				2
3			Bay Villa	Bay City				3
4			Alice Health care Center	Alice				4
5			Bangs Nursing Home	Bangs				5
6			Brazosview	Richmond				6
7			Courtyards at Fort Worth	Fort Worth				7
8			Faith Memorial	Pasadena				8
9			Golden Years	Marlin				9
10			Greenview Manor	Waco				10
11			Hillview Health & Rehab	Goldthwaite				11
12			Levelland Health Care	Levelland				12
13			Longmeadow Health Care	Justin				13
14			Memorial Medical Nursing Center	San Antonio				14
15			Mount Pleasant	Mount Pleasant				15
16			North Park Health & Rehab	McKinney				16
17			Pampa Health Care Center	Pampa				17
18			Park Highlands Health Care Center	Athens				18
19			Pleasant Springs Health Care Center	Mount Pleasant				19
20			Sweeny Health Care Center	Sweeny				20
21			Texoma Health Care Center	Sherman				21
22			The Park in Plano	Plano				22
23			Ashland Health & Rehab	Ashland				23
24			Southpointe Health Care Center	Greenfield				24
25			Virginia Highlands Health & Rehab Center	Germantown				25
26			Grande Prairie Health & Rehab Center	Pleasant Prairie				26
27			Pleasant Valley Health Care Center	Derry				27
28			The Village at Alameda	Albuquerque				28
29			Hobbs Healthcare Center	Hobbs				29
30			Lake Mead Health Care Center	Henderson				30

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 2/31/2020

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SSC Equity Holdings LLC
Street Address: 5300 W Sam Houston Pkwy N Ste 100
City / State / Zip Code: Houston, TX
Phone Number: (832 467 6000
Fax Number: (832 467 6384

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities				$	$		$ 36	1
2	6	Repair and Maintenance							17,891	2
3	19	Professional Services							14,269	3
4	20	Fee, Subscriptions and Promos							390	4
5	10	Nursing & Medical Records							171,303	5
6	21	Clerical & Gen Office Exp							2,581	6
7	24	Travel & Seminar							11,694	7
8	26	Insurance							9,314	8
9	36	Drpreiation							20,701	9
10	17	Communications							2,884	10
11	35	Rental and Lease								11
12	32	Interest Income/Expense							27,530	12
13	22	Payroll Taxes							24,555	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 303,148	25

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 32,309	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 31,668	2
3. Under or (over) accrual (line 2 minus line 1).		$ (641)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 31,930	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 31,289	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	29,109	8
	2016	29,520	9
	2017	30,135	10
	2018	30,803	11
	2019	31,406	12

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Nature Trail Health Care Ctr COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0047357

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-36-327-006	PT NE SW Beg 330.6' S of NE	$ 31,668.00	$ 31,668.00
2.		COR, S 175' W 300' S 125' W 230'	$	$
3.		N 300' E 530' to POB - 1001 S	$	$
4.		34th Street	$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,668.00	$ 31,668.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,558 B. General Construction Type: Exterior Brick Frame Concrete Block Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	74		2005	1974	$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Repair Automatic Transfer Switch			2005	1,953		11.5			1,953	9
10											10
11				2006	6,550		5			6,550	11
12	Tree Removal - Due to Storm			2006	17,600		10			17,600	12
13	Door - 42"			2006	5,245		10			5,245	13
14	Tree Removal			2006	2,273		10.25			2,273	14
15	Repair Sprinkler System			2006	33,750		10.25			33,750	15
16											16
17	Katolight Generator			2007	13,781		10			13,781	17
18	Electrical Work			2007	1,295		10			1,295	18
19	Repair Parking Lot			2007	89		10			89	19
20	Repair Parking Lot			2007	2,691		10			2,691	20
21	Interior Improvement			2007	1,710		10			1,710	21
22	Interior Improvement			2007	5,520		10			5,520	22
23	Interior Improvement			2007	2,230		10			2,230	23
24	Exterior Repairs			2007	6,852		10			6,852	24
25	New Dining Room Floor			2007	350		9.6			350	25
26	New Dining Room Floor			2007	2,094		9.83			2,094	26
27	Emergency Generator			2007	2,311		9.83			2,311	27
28	Repair Roof and Interior Rooms			2007	10,939		10.16			10,939	28
29	New Roof on Front Canopy			2007	3,434		10			3,434	29
30	New Roof on Kitchen Area			2007	3,450		10			3,450	30
31	Building Repairs			2007	8,890		10			8,890	31
32	Sprinkler Upgrade			2007	1,332		9			1,332	32
33	Shower Renovation			2007	2,529		9			2,529	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	7.5 Ton A/C Unit	2008	$ 5,395	$	9.41	$	$	$ 5,395	37
38	A T &T Circuit Conversion	2008	2,106		8			2,106	38
39	Maglock	2008	930		8.42			930	39
40									40
41	Bed Crash Rails	2009	1,661		7			1,661	41
42									42
43	Handrails	2010	10,441		7			10,441	43
44	30 Gallon Storage Container	2010	795		7			795	44
45	Remodel 5 Hallway Bathrooms (Contracted Total)-Carpentry	2010	4,939		6.3			4,939	45
46	Floor and Wall Mosaic Ceramic Tile for Bathroom Remodel	2010	7,571		6.3			7,571	46
47	Satellite Dish	2010	8,106		6			8,106	47
48	Satellite Dish	2010	4,893		6			4,893	48
49									49
50	Replace Shower Floor Liner, walls and fixtures - 5 bathrooms	2011	12,400		5.92			12,400	50
51	Replace Shower Floor Liner, walls and fixtures - 5 bathrooms	2011	3,306		5.92			3,306	51
52	2: Door Closers/Hinges	2011	1,125		5.83			1,125	52
53	Fire Alarm Horn Strobe Detector	2011	4,081		5.92			4,081	53
54	Replace Rooftop Unit Compressor	2011	1,245		6.42			1,245	54
55	Walkway Safety Bars	2011	1,715		5.83			1,715	55
56	Wall Mounted Kitchen Cabinet	2011	3,042		5.92			3,042	56
57	Marble Tops, Recessed bowls and faucets - 5 bath updates	2011	1,376		6			1,376	57
58	Maglock	2011	1,497		6.58			1,497	58
59	Annunciator	2011	3,661		5.75			3,661	59
60	Hand Rail	2011	8,988		5.42			8,988	60
61	Replace cement board and tile in bath areas	2011	3,419		5.33			3,419	61
62	Replace cement board and tile in bath areas	2011	3,419		5.08			3,419	62
63	3: Dry Pendent Sprinkler Heads	2011	2,495		5			2,495	63
64									64
65	10 Ton Heat/Cool Roof Top Unit	2012	25,200		5			25,200	65
66	Portable Storage	2012	2,000		10			2,000	66
67	Kitchen Hood System	2012	8,541		10			8,541	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 271,215	$		$	$	$ 271,215	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 271,215	$		$	$	$ 271,215	1
2	2: Thru Wall A/C Units	2013	1,502		4			1,502	2
3	Kichen Hood Syst - Bal Due	2013	6,608		4			6,608	3
4	Fire Alarm System Deposit	2013	12,475		3.75			12,475	4
5	Fire Alarm System Install	2013	12,475		3.5			12,475	5
6	5 Ton Kitchen A/C Unit	2013	2,850		3.5			2,850	6
7	Basement Sprinkler System	2013	4,400		3.5			4,400	7
8	Lvt Flooring Entry & Dining Room	2013	6,930		3			6,930	8
9	Fire Rated Door	2013	2,226		3			2,226	9
10									10
11									11
12	Facility Sign	2014	3,342		3			3,342	12
13	Polycom Phones	2014	521		3			521	13
14	2 Brick Pillars for New Sign	2014	2,316	237	9.75	237		1,603	14
15	A/C Compressor	2014	1,721	142	12	142		950	15
16	Lvt Flooring Entry & Dining Room Balance Due	2014	7,262	726	10	726		5,144	16
17	Install 3 MixingValves	2014	2,545	255	10	255		1,548	17
18									18
19	12,000 BTUH Heat Pump Mini Split System	2015	2,800	280	10	280		1,517	19
20	2 - 2 Ton Ductless Air Conditioners	2015	6,000	558	10.75	558		2,977	20
21	Water Heater	2015	6,902	690	10	690		3,681	21
22	3 Mixing Valves	2015	2,545	254	10	254		1,357	22
23									23
24	Nurse Call System Install	2016	3,975	398	10	398		1,855	24
25	Down Payment for Material for Roof Replacement	2016	55,895	5,684	9.8	5,684		25,105	25
26	Garbage Disposal	2016	1,215	243	5	243		1,053	26
27	Phone System Smartups 1500VA	2016	755	76	10	76		321	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 418,475	$ 9,543		$ 9,543	$	$ 371,655	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 418,475	$ 9,543		$ 9,543	$	$ 371,655	1
2	Final Payment for Roof Replacement - Materials and Labor	2017	62,041	6,204	10	6,204		24,816	2
3	Rebuild Entry Vestibule with sliding doors, flooring, windows, an	2017	26,243	1,749	15	1,749		7,109	3
4	10 x 12 Metal Utility Storage	2017	2,487	249	10	249		974	4
5	Parking Lot and Sidewalk Seal and Restripe	2017	2,000		2			2,000	5
6	Flushable Clinical Sink with new water line and bed pan washer	2017	6,600	344	19.16	344		1,177	6
7									7
8	10 Ton RTU for VA Wing	2018	29,871	2,987	10	2,987		9,210	8
9	2: Steel 90 Min Fire Door - East and West Halls	2018	4,500	243	18.5	243		669	9
10	Compressor for A/C in Dining Room	2018	1,386	92	15	92		239	10
11	12x24 Metal Storage Sheds	2018	8,386	838	10	838		2,116	11
12									12
13	LVT Flooring - Physical Therapy	2019	6,847	685	10	685		1,255	13
14	Nurse Station Rebuild - Demo, enlarge and add cabinets	2019	21,800	1,453	15	1,453		2,351	14
15	Half Wall Build out in Reception/Dining Area	2019	4,200	280	15	280		452	15
16	Roam Alert System	2019	2,459	246	10	246		430	16
17	12x12 Smoking Shelter	2019	23,757	2,376	10	2,376		2,655	17
18									18
19	Roam Alert System - Parts and Installation	2020	2,319	380	10	380		380	19
20	12 x 12 Smoking Shelter Inv #3	2020	5,218	522	10	522		522	20
21	Delayed Egress Maglock - East Wing	2020	950	95	10	95		95	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 629,539	$ 28,286		$ 28,286	$	$ 428,105	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 280,116	$ 15,203	$ 15,203	$		$ 192,804	71
72	Current Year Purchases	833	102	102			102	72
73	Fully Depreciated Assets	(7,367)						73
74								74
75	TOTALS	$ 273,582	$ 15,305	$ 15,305	$		$ 192,906	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 903,121	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 43,591	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 43,591	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 621,011	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: SSC Equity Holdings LLC

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1974	74	10/11/2013	$	12		3
4	Additions							4
5								5
6								6
7	TOTAL		74		$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 06/02/2004
Ending 05/31/2026

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-03	5345 hrs	$ 192,203		$	$	5,345	$ 192,203	1
2	Licensed Speech and Language Development Therapist	10a-03	2380 hrs	120,402				2,380	120,402	2
3	Licensed Recreational Therapist	10a-03	hrs							3
4	Licensed Physical Therapist	10a-03	6229 hrs	231,513				6,229	231,513	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				144,361		144,361	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$ 544,118		$	$ 144,361	13,954	$ 688,479	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2020 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 400	$	1
2	Cash-Patient Deposits	66,243		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	562,458		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	431		6
7	Other Prepaid Expenses	4,733		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 634,265	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	52,934		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	5,051,739		15
16	Equipment, at Historical Cost	273,583		16
17	Accumulated Depreciation (book methods)	(1,687,359)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,690,897	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,325,162	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 828,232	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	403,608		30
31	Accrued Taxes Payable (excluding real estate taxes)	75,915		31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,668		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	37,486		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,376,909	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Capital Lease/Intercompany	1,543,178		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,543,178	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,920,087	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,405,075	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,325,162	$	48

***(See instructions.)**

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,304,325	1
2	Restatements (describe):	8	2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,304,333	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	100,742	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 100,742	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,405,075	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,839,280	1
2	Discounts and Allowances for all Levels	(11,716,173)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,123,107	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,469,579	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,469,579	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	(212)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	174,718	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 174,506	23
	D. Non-Operating Revenue		
24	Contributions	200	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 200	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	General Rental Receipts	703	28
28a	Misc Receipts Vending		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 703	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,768,095	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	623,459	31
32	Health Care	2,385,336	32
33	General Administration	1,510,557	33
	B. Capital Expense		
34	Ownership	793,756	34
	C. Ancillary Expense		
35	Special Cost Centers	222,898	35
36	Provider Participation Fee	131,347	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,667,353	40
41	**Income before Income Taxes (line 30 minus line 40)****	100,742	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 100,742	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 1,547,399	44
45	Private Pay - Net Inpatient Revenue	162,617	45
46	Medicare - Net Inpatient Revenue	1,107,143	46
47	Other-(specify) HMO/Ins	33,613	47
48	Other-(specify) VA/Hospice/Charity	1,272,335	48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 4,123,107	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,887	2,068	$ 83,458	$ 40.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,986	14,062	506,105	35.99	3
4	Licensed Practical Nurses	10,113	10,991	252,800	23.00	4
5	CNAs & Orderlies	35,519	37,592	593,298	15.78	5
6	CNA Trainees					6
7	Licensed Therapist	12,509	13,997	547,014	39.08	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,861	2,067	36,540	17.68	9
10	Activity Assistants	1,056	1,113	13,060	11.73	10
11	Social Service Workers	1,879	2,095	37,372	17.84	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,743	2,127	42,999	20.22	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	1,967	2,095	109,898	52.46	20
21	Assistant Administrator					21
22	Other Administrative	5,466	5,892	187,303	31.79	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,982	2,188	36,999	16.91	31
32	Other Health Care(specify)	1,933	2,147	32,644	15.20	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,901	98,434	$ 2,479,490 *	$ 25.19	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 313,662	1-3	35
36	Medical Director		33,590	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		8,186	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant		919	10a-3	42
43	Speech Therapy Consultant				43
44	Activity Consultant		2,439	11-3	44
45	Social Service Consultant		2,399	12-3	45
46	Other(specify)		7,377	10-3	46
47	Administrative		65,860	39-3	47
48	Laboratory & Xray		9,420	39-3	48
49	TOTAL (lines 35 - 48)		$ 443,852		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Nature Trail Health Care Ctr # 0047357 Report Period Beginning: 01/01/2020 Ending: 12/31/2020

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Connie V Bonner	Administrator	0	$ 118,150
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 118,150

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Equifax	Background Checks	$ 710
Avelere Health	Vantage CPS	443
Docusign Inc	New Hire Paperwork	73
LexisNexis	Regs Resource	78
Mgmt & Network Srvcs	Network Membership	375
NRC Health	Survey Program	177
Pinnacle Quality Insight	Cust Satis Survey	1,056
TOTAL (agree to Schedule V, line 19, column 3)		
(For legal fee disclosure, see page 39 of instructions)		$ 2,912

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 37,498
Unemployment Compensation Insurance	12,413
FICA Taxes	178,502
Employee Health Insurance	128,259
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Life Insurance	1,563
Other Benefits	20,551
Payroll Taxes	24,555
TOTAL (agree to Schedule V, line 22, col.8)	$ 403,341

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	9,383
Health Care Worker Background Check	7,919
(Indicate # of checks performed)	
Patient Background Checks	
Publications and Manuals	916
Dues	8,053
Other Licenses	5,488
Fees, Subscriptions and Promos	390
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,149

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,752
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,752

**See instructions.

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health care Association $6,031**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,900** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **131,347**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **Yes**
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained?
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **BDO Seidman LLC (Corporate Level)**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **NA**
Attach invoices and a summary of services for all architect and appraisal fees.